State of California – Health and Human Services Agency
Department of Alcohol and Drug Programs

CALIFORNIA ACCESS TO RECOVERY EFFORT (CARE)

PROGRAM APPLICATION FOR RECOVERY SUPPORT SERVICE PROVIDERS

Instructions
Please type or print legibly and mail completed application to: **Department of Alcohol and Drug Programs, CARE Program, 1700 K Street, 4th Floor, Sacramento, CA 95814.** Retain a copy of the completed application for your files. Questions can be directed to Peggy Bean at (916) 322-0495.

SECTION 1: PROGRAM INFORMATION SHEET

PROGRAM NAME:_____

DOING BUSINESS AS (DBA) NAME:_____

TAX ID NUMBER (TIN):_____

ADDRESS: _____
(location where services will be provided)

MAILING ADDRESS:_____
(If different from above)

Will services to voucher recipients be provided at other locations? **Yes [ ] No [ ]**
If yes, please fill out the attached ***Program Information Sheet Addendum*** for each additional service location.

Please list the following contact/referral information for the CARE Program Directory. This information will be available to clients and assessment centers for referral purposes.

CONTACT NAME:_____

PHONE: _____ **TOLL FREE #**:_____

FAX: _____ **TTY**:_____

EMAIL: _____

WEBSITE:_____

Do you want a link to this website on the CARE Program Directory? **Yes [ ] No [ ]**

If different from above, please list the following contact information for all other program inquiries (from ADP and MAXIMUS)

CONTACT NAME:_____

PHONE: _____ **TOLL FREE #**:_____

FAX: _____ **TTY**:_____

EMAIL: _____

HOURS OF OPERATION

Monday: _____ Friday: _____
Tuesday: _____ Saturday:_____
Wednesday:_____ Sunday:_____
Thursday: _____

CORPORATE STATUS

[ ] Profit Corporation [ ] Nonprofit Corporation [ ] Governmental Entity

[ ] Sole Proprietor [ ] Partnership

TYPE OF ORGANIZATION

[ ] Advocacy group
[ ] Business/employer
[ ] Community-based organization
[ ] Education/training
[ ] Faith-based organization
[ ] Healthcare provider
[ ] County/city government

PREFERRED GROUPS SERVED/PROGRAM SPECIALTIES (check all that apply)

[ ] 12-17 year olds
[ ] 18-20 year olds
[ ] Female only
[ ] Male only
[ ] Dual diagnosis
[ ] Families
[ ] Specific language capacity (please list):_____
[ ] Specific culture (please list):_____

RECOVERY SUPPORT SERVICES OFFERED (check all that apply)

[ ] Employment services (specify types):_____

_____

[ ] Educational services (specify types):_____

_____

[ ] Mentoring
[ ] Spiritual coaching
[ ] Transportation
[ ] Childcare

SERVICE AREA (check one only)

[ ] Entire Los Angeles County
[ ] Selected zip codes in Los Angeles County (please list):_____
_____
[ ] Entire Sacramento County
[ ] Selected zip codes in Sacramento County (please list):_____
_____

PROGRAM PROFILE

The following program information will be made available to clients to assist them select providers whose services reflect their needs and personal preferences. The information will be part of the CARE Program Directory available on the website or through the call-in center. Please be as descriptive as possible to help clients make appropriate, informed choices. **However, the entire program profile should not exceed one double-spaced, typewritten page.**

Program Mission and Philosophy Statement

Please attach a written statement(s) describing the program's mission and/or philosophy.

Program Description

Please provide a description of the services offered by the program, the settings in which they are offered, the type of client appropriate for the program's services, and the program's approach.

AUTHORIZED SIGNATURE

The undersigned affirms that the facts contained in this application and supporting documents are true and correct.

If the applicant is a **sole proprietor**, the proprietor must sign the application.
If the applicant is a **partnership**, each partner must sign the application
If the applicant is a **firm, association, corporation, or governmental entity**, the chief executive officer or the individual legally responsible for representing the firm, association, corporation or governmental entity must sign the application. The application must include the resolution or board minutes authorizing the individual to sign.

Name Typed: _____

Title: _____

Signature: _____

Date: _____

SECTION 2: PROGRAM INFORMATION SHEET ADDENDUM

Complete the sections below if you have additional or different locations. Please fill out one addendum for each additional service delivery location.

Please list the following contact/referral information for the CARE Program Directory that will be available to clients and assessment centers for referral purposes.

PROGRAM NAME:_____

ADDRESS: _____
(location where services will be provided)

CONTACT NAME: _____

PHONE: _____ **TOLL FREE #**: _____

FAX: _____ **TTY**: _____

EMAIL: _____

WEBSITE: _____
Do you want a link to this website on the CARE Program Directory? **Yes [ ] No [ ]**

If different from above, please list the following contact information for other program inquiries (from ADP and MAXIMUS).

CONTACT NAME: _____

PHONE: _____ **TOLL FREE #**: _____

FAX: _____ **TTY**: _____

EMAIL: _____

HOURS OF OPERATION:
Monday: _____ Friday: _____
Tuesday: _____ Saturday: _____
Wednesday:_____ Sunday: _____
Thursday: _____

PREFERRED GROUPS SERVED/PROGRAM SPECIALTIES (check all that apply)
[ ] 12-17 year olds
[ ] 18-20 year olds
[ ] Female only
[ ] Male only
[ ] Dual diagnosis
[ ] Families
[ ] Specific language capacity (please list):_____
[ ] Specific culture (please list):_____

RECOVERY SUPPORT SERVICES OFFERED (check all that apply)

[ ] Employment services (specify types):_____

_____

[ ] Educational services (specify types):_____

_____

[ ] Mentoring
[ ] Spiritual coaching
[ ] Transportation
[ ] Childcare

SERVICE AREA (check one only)

[ ] Entire Los Angeles County
[ ] Selected zip codes in Los Angeles County (please list):_____
_____
[ ] Entire Sacramento County
[ ] Selected zip codes in Sacramento County (please list):_____
_____

SECTION 3: DOCUMENTATION REQUIREMENTS FOR RECOVERY SUPPORT SERVICE PROVIDERS

Please attach the following:

- A signed copy of the Program Information Sheet (Section 1), including the Program Profile.
- If the organization is applying for more than one service location, a copy(ies) of the Program Information Sheet Addendum (Section 2)
- A signed Program Acknowledgements page (Section 4)
- A completed Program and Staff Qualifications page (Section 5).
- A signed Certification of Compliance with Eligibility Criteria page (Section 6).

SECTION 4: PROGRAM ACKNOWLEDGEMENTS PAGE

The undersigned acknowledges that he/she understands their organization's role and general responsibilities under the CARE Program, as described in the CARE Program Overview, and agrees to comply with the requirements listed therein and summarized below:

- Accept vouchers from clients who are appropriate for the provider's services, as long as there is available capacity.
- Utilize staff and/or volunteers with the necessary qualifications, training, and knowledge to provide the specified services.
- Accept the authorized services and rates offered by the CARE program and be reimbursed after services are provided.
- Participate in performance assessments and regional performance meetings.
- Participate in training provided by MAXIMUS and/or ADP to carry out the duties and responsibilities under the program.
- Notify MAXIMUS whenever there are changes to program information, such as a change in program location, contact information, types of services offered, hours of operation, etc.
- Provide information to voucher clients regarding the availability of ADP to assist in resolving disputes between the provider and the client.
- Secure and protect the privacy and confidentiality of client information in accordance with 42 CFR and HIPAA as applicable.
- Collect all mandated data and report such data to MAXIMUS within the specified timeframes.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

SECTION 5. PROGRAM AND STAFF QUALIFICATIONS

Briefly describe each recovery support service you plan to provide as part of the CARE program.

Briefly describe the organization's history and experience providing the recovery support services which you plan to provide as part of the CARE program.

Describe the minimum qualifications and/or training required of program staff and/or volunteers

SECTION 6. CERTIFICATION OF COMPLIANCE WITH ELIGIBILITY CRITERIA

[ ] I certify that the applicant organization is accredited, certified, or approved by a nationally recognized accrediting organization or state approval agency for the specific service(s) for which it is applying. A copy of such approval or accreditation is enclosed.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

[ ] The applicant organization is not accredited or state approved for the specific service(s) for which it is applying, but the organization meets the following eligibility criteria:

- Is registered with the California Secretary of State's Office;
- Meets all required federal, state, and/or local zoning codes and other regulations;
- Has an ethical framework for guiding employee, volunteer, and client interactions that addresses roles, boundaries, supervision, training, and client rights and grievance procedures;
- Has a risk management strategy including adequate insurance to cover risks; and
- Has at least one year of experience providing the same type of recovery support services to youth in their local community.

By signing below, I certify that my organization meets the eligibility criteria stated above. I understand that ADP may visit my organization's program site(s) for the purpose of clarifying information contained in the application and/or determining whether the organization is eligible to participate in the CARE program. By act of submitting this application, I agree to allow and assist ADP in fully and freely conducting these onsite procedures and to provide reasonable access to the organization's premises, staff and/or volunteers, and requested information.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____